

JANE HARRIES

STUDENT NUMBER: HRRJAN001

**A GENDERED PERSPECTIVE OF A COMMUNITY'S PERCEPTION OF  
MICROBICIDE INTRODUCTION**

DISSERTATION

Submitted in partial fulfillment of the requirements for the degree of Masters in Public Health

School of Public Health and Family Medicine

University of Cape Town

August 2005.

The copyright of this thesis vests in the author. No quotation from it or information derived from it is to be published without full acknowledgement of the source. The thesis is to be used for private study or non-commercial research purposes only.

Published by the University of Cape Town (UCT) in terms of the non-exclusive license granted to UCT by the author.

# TABLE OF CONTENTS

<b>DECLARATION</b> .....	<b>i</b>
<b>ACKNOWLEDGEMENTS</b> .....	<b>ii</b>
<b>ABSTRACT</b> .....	<b>iii</b>
<b>CHAPTER 1: BACKGROUND AND RATIONALE</b> .....	<b>1</b>
<b>CHAPTER 2: LITERATURE REVIEW</b> .....	<b>5</b>
<b>CHAPTER 3: METHODOLOGY</b> .....	<b>15</b>
Study site.....	15
Study design.....	16
Sampling .....	17
Data collection .....	18
Data analysis .....	19
<b>CHAPTER 4: RESULTS</b> .....	<b>21</b>
<b>Sexual relations: Implications for sexual and intravaginal practices</b> .....	<b>23</b>
<i>“Wet sex”- meanings attached to wetness</i> .....	<b>23</b>
Infidelity.....	24
“Not wet sex” .....	26
Wetness and STIs.....	27
<b>Condom use</b> .....	<b>28</b>
Sexual pleasure .....	30
Stigma .....	32
Differing contexts of condom use.....	33
Impact on fertility .....	34
<b>Suspicion and mistrust</b> .....	<b>35</b>
Proof of safety and effectiveness .....	35
Product characteristics .....	36
<b>Partner communication</b> .....	<b>37</b>
<b>Covert use</b> .....	<b>38</b>
<b>Gender-based violence : Rape and sexual coercion</b> .....	<b>39</b>

**CHAPTER 5: DISCUSSION .....42**  
**CHAPTER 6: CONCLUSION.....53**  
**REFERENCES.....56**  
**APPENDICES.....66**

University of Cape Town

## DECLARATION

I, Jane Harries, hereby declare that the work on which this thesis is based is my original work (except where acknowledgements indicate otherwise), and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

I empower the University of Cape Town to reproduce for the purpose of research either the whole or any portion of the contents in any manner whatsoever.

Signed by candidate

Signature

12 August 2005

Date

## ACKNOWLEDGEMENTS

I would like to thank the following:

- My primary supervisor, Phyllis Orner, and, Di Cooper, Women's Health Research Unit, School of Public Health and Family Medicine, University of Cape Town
- Research Team for the larger project  
Phyllis Orner, Di Cooper, Jennifer Moodley and Margaret Hoffman from the Women's Health Research Unit, University of Cape Town
- Julie Becker and Rasha Dabash from EngenderHealth
- Hillary Bracken from the Population Council
- Elizabeth McGrory from the International Partnership for Microbicides
- Field workers
- Community Liaison Officer
- Community respondents for their time and willingness to share their perspectives
- My family

The larger project was supported by the U.S. Agency for International Development and the John D. Rockefeller Foundation.

## ABSTRACT

South Africa is currently experiencing one of the worst HIV/AIDS epidemics in the world. The epidemic features distinctive age and gender distributions, with young women at greatest risk, and overall proportionally more women affected than men.

Current HIV prevention strategies are limited as women's risk is frequently derived from their partners' behaviors rather than their own. The development of a microbicide for HIV prevention may offer the possibility of reducing women's risk of infection in situations where other more effective methods cannot be used. An environment conducive to introducing a microbicide is critical to avoid some of the obstacles that have historically inhibited similar technological innovations.

This study, which formed part of a larger qualitative research project, explored local sexual practices as they related to a female-initiated intravaginal product and the broader gender and sexual relations that underpin perceptions around possible microbicide use. An understanding of gender related factors is crucial in exploring women's access and ability to use a microbicide.

Twenty-two focus groups and 11 in-depth interviews were held with community participants who resided in Langa, Cape Town. Data was analyzed using a grounded theory approach.

Respondents expressed keen support for microbicides, underscored by desperation related to the AIDS epidemic and recognition of women's greater risk. Discussions amongst both women and men around microbicide use revealed numerous ways in which a new preventive technology could impact on broader gender relations. Issues around condom use, partner communication, meanings attributed to changes in vaginal moisture levels, covert use, potential for partner discord, and gender-based violence were linked by respondents to the varying ways in which the microbicide could impact on their daily lives.

While the microbicide has the potential to "empower" women, inequitable gender relations and other social and economic problems will need to be addressed in order to halt the spread of the AIDS epidemic in South Africa.

## CHAPTER 1

### BACKGROUND AND RATIONALE

South Africa is currently experiencing one of the worst HIV/AIDS epidemics in the world. A seroprevalence of HIV infection of 29.5% was reported from a national survey among women attending public sector antenatal clinics in 2004 (Department of Health, 2004), and the numbers of reported deaths have shown an unabated rise, particularly among young adults (Bradshaw, Laubscher, Dorrington, Bourne & Timaeus, 2004).<sup>1</sup>

The epidemic features distinctive age and gender distributions, with young women at greatest risk, and overall proportionally more women affected than men (Abdool Karim & Abdool Karim, 1999; UNAIDS/WHO, 2004). Women's greater vulnerability to HIV infection is largely driven by the gender inequities that pervade South African society. Women's economic dependence on men increases their vulnerability to HIV by constraining their ability to negotiate the use of a condom, discuss fidelity with their partners, or leave risky relationships (Dunkle et al., 2004). In addition, cultural assumptions such as men's "right" to engage in sexual relations with multiple partners mean that sexual intercourse, even with spouses and intimate partners, carries high levels of risk for many women (Heise, 1999; Wood & Jewkes, 1997). Women's vulnerability to

---

<sup>1</sup>Groenewald, Nannan, Bourne, Laubscher & Bradshaw (2005) have argued that monitoring the actual number of AIDS deaths is problematic due to both the under-registration and misclassification of the causes of death.

HIV exposure is further exacerbated by gender-based violence, including intimate partner violence (Dunkle, et al., 2004).

Current HIV prevention strategies, such as reducing the number of sexual partners, mutual monogamy and abstinence, condom use and the treatment of sexually transmitted infections (STIs), are often not possible for many women whose economic dependence on their sexual partners may preclude the adoption of safer sexual behaviours, particularly given that their risk derives primarily from their partners' behaviour rather than their own (Cooper et al., 2004). These obstacles are further compounded by the fact that many STIs are asymptomatic in women. There is thus an urgent need to extend the range of prevention options particularly those that give women more control over their own bodies and lives.

It is within this context that there has been an increasing interest in the development of microbicides (a generic term for an agent that blocks, kills or immobilises pathogens) as a female initiated intra-vaginal method for HIV prevention (Alliance for Microbicide Development, 2003). Vaginal microbicides are currently being developed and tested to address this need and could be available in 5 to 7 years time (Rosenberg, 2005).

Vaginal microbicides may be available in several forms, as a gel, suppository, ring or film. Microbicides used for vaginal sex are inserted by women and therefore in theory, require minimal involvement of men.

Introducing microbicides is likely to be complex for contextual and product-related reasons. Firstly, microbicides, especially the first generation of products, are likely to be only partially effective, with lower effectiveness than male condoms in preventing HIV transmission. It will therefore be important for users to understand the concept of risk reduction, since a more effective method of HIV prevention, condoms, already exists. Yet, in situations where condoms are not a viable option, microbicides may offer an important alternative for a woman to protect herself from HIV infection (Foss, Vickerman, Heise & Watts, 2003). Secondly, by potentially providing women with more power and control over their sexual lives and bodies, microbicides may challenge existing gender power dynamics. For these reasons, it is important to understand the gender-related, social, cultural, and structural contexts before microbicides are introduced. Furthermore, it is crucial to consult with communities and possible users as they are often overlooked in the introduction phase of a new technology.<sup>2</sup>

This study, which formed part of a larger qualitative research project (Orner et al., 2004), focuses on community participants' perceptions and the meanings they attach to microbicides and how this might impact on their daily lives. More specifically, it will focus on the broader gender and sexual relations that underpin these perceptions. The study aims to provide more detailed information on microbicide acceptability from the perspective of potential users (rather than from the perspective of policy makers and

---

<sup>2</sup> The recent controversy surrounding the Tenofovir trials in Cameroon highlights the importance of community involvement and ongoing feedback to communities and other stakeholders. Tenofovir is an antiretroviral drug currently used for treatment of HIV disease. Tenofovir is also being studied to determine whether it is appropriate for use as pre-exposure prophylaxis for the prevention of HIV infection.

health service providers who were also a focus in the larger study). By giving “exclusive” voice to the people who might use microbicides, this research will offer opportunities to identify and address users needs and concerns.

**Objectives of the study were:**

1. To explore, using the data from the larger project, community participants’ understandings and perceptions of microbicides as they relate to interpersonal relations and sexual practices.
2. To understand the impact of gender and gender relations on community members’ understandings and perceptions of microbicides.

University of Cape Town

## CHAPTER 2

### LITERATURE REVIEW

This literature review relates to four areas of importance to the research project:

(1) A gender perspective to frame the argument; (2) lessons learnt from the introduction of other female initiated HIV prevention methods and contraceptive technologies; (3) microbicide acceptability and clinical trials in Southern and Central Africa, and (4) intravaginal practices linked to notions of “wet” and “dry sex”.

#### **Gender**

The research findings were analysed through a gender lens, that is, taking cognizance of underlying gender relations and identities and, pertinent to this research, unequal power relations that exist between men and women in sexual decision-making strategies.

Identity, more specifically gender identity, can be conceptualised as a form of agency, constructed and negotiated in historical and political contexts. Feminist scholarship has been attentive to the multiplicity of social relations that structure women’s identities in interdependent and contradictory ways (Annandale & Clarke, 1996; de Lauretis, 1986)<sup>3</sup>.

Post-colonial feminist theorists such as Minh-ha (1989) and Mohanty (1991) have asserted, that Western feminism has tended to homogenize “third world women” (Mohanty, 1991, p.53). The experience of being a woman is different dependent on how one is positioned in terms of race, class, ethnicity, geographical location, age and

religion. Thus as a contested domain and a negotiable social process, gender is fluid, complex and multi-faceted (Fraser, 1992).

Feminist theorists have also challenged the manner in which medical knowledge and scientific discourse encodes dominant representations of gender and of women (Ginsburg & Rapp, 1995; Martin, 1989). Related to this, feminist theorists have attempted to demonstrate that gender is socially constructed and not a biological given. In addition, they have challenged the notions of sex, gender and sexual differences as being fixed binary categories (Braidotti, 1991; Moore, 1994), thus providing an important theoretical framework for reconceptualizing unequal gender relations and the manner in which gender and sexual relations are constructed and contested in diverse social settings.

### **Introduction of new reproductive technologies**

One of the rationales for undertaking the larger research project was to explore introduction issues before microbicides became available and to learn from experiences with other reproductive technologies and innovations (Hardee, Balogh & Villinski, 1997; Kaler, 2001; Simmons et al., 1997). Experience with introducing new health technologies has demonstrated the critical importance of understanding the gender-related, social, economic, and cultural contexts before innovations are introduced (Simmons et al., 1997). Lessons from the past with the introduction of new contraceptive technologies such as Norplant and the IUD (intrauterine device) and a female initiated HIV prevention method such as the female condom, provide important information on issues to be

---

<sup>3</sup> In talking about feminist scholarship I acknowledge differences within the discursive boundaries of feminist theory, discourse and praxis.

considered and what to avoid in the future (Hoffman, Mantell, Exner & Stein, 2004; Simmons et al., 1997). Norplant implants were introduced into family planning programs in the 1980s mostly in the developing world, and were a technologically complex contraceptive method (Hardon, Mutua, Kabir & Engelkes, 1997). Transfer of complicated technology can place an added burden on health delivery systems particularly in resource-poor settings. Although Norplant was safe, effective, and long acting (five years), it also had side effects (mostly bleeding irregularities), and issues with quality of care, provider-dependency, and lack of appropriate counseling (Simmons, 1997). Proper insertion, removal, and adequate counseling about side effects proved difficult in some resource-poor settings, especially when the method was introduced too quickly, as in Indonesia, where five million women were given Norplant (Tuladhar, Donaldson & Noble, 1998).

The Norplant experience highlights the importance of initial and follow-up provider instruction, sensitive and accurate counseling of potential users, and involvement of community and women's health advocacy groups (Hardee et al., 1997; Hardon et al., 1997).

The IUD, like Norplant, is a provider dependent contraceptive. The IUD was introduced in India in the 1960s, but planners failed to adequately anticipate several key factors before introducing the method (Simmons et al., 1997). Providers were not given adequate training and counseling on insertion, removal and anticipated side effects, overlooked logistical and supply demands that the new method would place on the delivery system,

and did not support women as they experienced the physical and social consequences of IUD use (Simmons et al., 1997). As a result, after an initial favourable response, the method became widely discredited (Simmons et al., 1997).

In response to difficulties associated with the introduction of new contraceptive technologies as discussed above, the UNDP/UNFPA/WHO and World Bank Special Programme of Research, Development and Research Training in Human Reproduction, developed in the 1990s a new “strategic approach” to contraceptive introduction. This approach shifted the emphasis from the promotion of a particular technology, to quality of care issues, a reproductive health focus, and to incorporate the perspectives of a broad range of stakeholders, including those of users, providers, managers, policy makers, community groups and women’s health advocates (Simmons et al., 1997).

Microbicides share certain characteristics with contraceptives: both require discussions about sexuality, a difficult undertaking for many women and men, and both have the potential to “empower” women by giving them control over their reproductive lives and health.

Currently, the female condom remains the only female initiated HIV prevention method, not too dissimilar to the anticipated microbicide (Green et al., 2001; Hoffman et al., 2004). Introduction of the female condom has been problematic largely related to cost, access, product positioning and marketing, and incorporating it into the contraceptive method mix (Hoffman et al., 2004). Hoffman et al. (2004), argued that efforts to resolve

the challenges posed by the female condom will lay the groundwork for the promotion of other female initiated barrier methods for HIV prevention such as the microbicide. Kaler (2001), in studies undertaken in Kenya and South Africa, two countries in which the female condom was introduced, deconstructed the notion of “empowerment” as it relates to the female condom and pointed to the ambiguities of the female condom as a marker of “female empowerment” (Kaler, 2001, p.783). She argued that even though the female condom affords a certain amount of autonomy in that it is self-controlled, women’s “empowerment” could pose a problem if this very empowerment is conceived of as something that diminishes men’s power. Thus, attention to local social context and existing gender relations need to be taken into account in the process of introducing new reproductive health technologies (Susser & Stein, 2000).

#### **Microbicide acceptability research**

Because the effectiveness of microbicides, similar to other reproductive health technologies, will depend on their consistent use, their acceptability to potential users is critical (Braunstein & van de Wijgert, 2003). Acceptability has been defined as:

“[For] a product to be acceptable, a potential user must fully understand the potential benefits of using the product, the elements of correct use, its potential side effects, and alternative methods, and be willing and able to consistently apply such knowledge to the use of the technology in everyday life” (Elias & Coggins, 2001, p.164, cited in Braunstein & van de Wijgert, 2003, p.1).

Mantell et al. (2005), in their review of current microbicide acceptability research, highlighted the importance of attention to local social context. Of the 61 studies reviewed, more than half assessed acceptability based on the physical characteristics of microbicides with little attention to the various situations in which microbicides could be used. They argued that as acceptability is likely to be one of the key determinants in microbicide use, in-depth understanding of the social processes that shape microbicide acceptability across diverse populations would become increasingly valuable. Areas to be addressed in future microbicide acceptability research include cultural norms regarding intravaginal practices and gender relations. Failure to understand the key factors associated with microbicide acceptability is likely to hinder the adoption and continued use of products that are effective in preventing HIV infection (Mantell et al., 2005, p. 312).

### **Intravaginal practices: sexual and gender relations**

Intravaginal use of microbicides and its potential impact on sexual relations have been cited as potential barriers to microbicide acceptability and use (Braunstein & van de Wijgert, 2003).

A significant body of literature and interest has emerged over the past twelve years around the practice of “dry sex”, which has been “identified” in several countries in Central and Southern Africa. Dry sex has been defined as a preference for a dry, tight vagina during sexual intercourse. This is achieved by placing various drying agents such as traditional medicines and leaves, pharmaceutical products and cleaning agents into the

vagina prior to sex (Beksinska, Rees, Kleinschmidt & McIntyre, 1999; Brown, Ayowa & Brown, 1993; Civic & Wilson, 1996; Karim, Karim, Soldan & Zondi, 1995; Morar & Karim, 1998; Runganga, Pitts & McMaster, 1992; Sandala et al., 1995). Concern over this practice has arisen, firstly, as a possible risk factor towards HIV infection and other STIs and secondly, that the microbicide as a gel might not be acceptable in countries where “dry sex” is practiced.

Intravaginal practices, including wiping, douching or inserting various drying agents into the vagina to facilitate “dry sex”, have been hypothesized to increase women’s risk of HIV infection (Beksinska, et al., 1999; Brown, Ayowa & Brown, 1993; Mann et al., 1998). However, epidemiologic data on the prevalence of these practices and associations with HIV and other STIs are limited (Myer et al., 2004). Although some studies have shown an increased risk of HIV among women reporting some type of intravaginal practice (Dallabetta, et al., 1995; Mann, et al., 1998) they did not adjust for behavioural risk factors for HIV infections (Myer et al., 2004). Because intravaginal practices are commonly associated with increased high-risk behaviours appropriate adjustments are necessary to avoid confounding. Most research to date has focused on antenatal clinic attenders, commercial sex workers and STD clinic attenders with little attention given to intravaginal practices and HIV infection within general population samples (Myer et al., 2004).

Myer et al.’s (2004) study investigated the associations between intravaginal practices and HIV and other STIs amongst women attending two clinics in Cape Town.

This study was undertaken in an area similar to our study site in terms of demographics and thus has significance to our findings. The study found that 29 % of women reported some form of intravaginal practice. However, practices to dry the vagina before sexual intercourse were rarely reported compared with behaviours associated with regular vaginal cleansing or personal hygiene practices. Furthermore, this study highlighted important issues that could impact on microbicide use and efficacy. For instance, intravaginal cleansing practices before or after microbicide insertion could affect the efficacy of the product.

While some studies have explored the relationship between “dry sex” and an associated increased risk of HIV (Beksinska, et al., 1999; Brown, Ayowa & Brown, 1993; Mann et al., 1998), others have examined the impact of “dry sex” on current and future HIV prevention technologies such as the condom (female and male) and microbicide (Civic & Wilson, 1996; van de Wijgert et al., 1999). The argument being for the latter that individuals who prefer a non-lubricated vagina during sexual intercourse may be reluctant to use condoms or microbicides, which could result in additional lubrication.

Concerns with regards to added vaginal lubrication during sex or “wetness” have emerged as a potential barrier to microbicide acceptability. The majority of first generation microbicides have been formulated as gels that will likely lubricate the vagina during sex (Alliance for Microbicide Development, 2003). Initially researchers were concerned that gels might not be acceptable in countries where “dry sex” was practiced (Elias & Heise, 1993). Early safety trials indicated that individuals or couples who

practice dry sex were in fact interested in trying a microbicide, particularly if it would protect them from HIV (van de Wijgert et al., 1999). These studies suggested that an understanding of cultural norms, preferences and practices with regards to lubrication can lead to improved understandings of people's vulnerability to HIV, and can influence how microbicides are introduced and used (Braunstein & van de Wijgert, 2003).

Braunstein and van de Wijgert (2003) in a preliminary study on cultural norms, preferences and practices regarding vaginal lubrication during sex, suggested numerous reasons why women engage in vaginal practices, namely, to promote cleanliness, fertility, good health and to enhance their partners' sexual pleasure. A limitation of their study is that only key informants, "highly educated female professionals" (Braunstein & van de Wijgert, 2003, p.16) were interviewed and not the people who were actually involved in these practices. Key informants from countries in Africa, Asia, Latin America and North America reported differing meanings attached to wetness. However, some common themes emerged. These included associations of added vaginal wetness with a "loose" vagina, which in turn reduces sexual pleasure for male partners; as a result of a woman's sexual arousal; a sign of infidelity or promiscuity; a lack of cleanliness, and a symptom of vaginal infection.

The association of added lubrication or wetness with promiscuity and infidelity were to emerge in several studies (Coggins et al., 2000; Mason et al., 2003; Orner et al., 2004; Ray, Gumbo & Mbizvo, 1996) and can be viewed as reflective of gender power relations and sexual decision-making processes. An understanding of local sexual practices is

crucial to understanding how new technologies are received and the underlying gender relations and possible sites of resistance. Unequal gender relations could preclude attempts to introduce a new HIV prevention technology such as the microbicide.

University of Cape Town

## CHAPTER 3

### METHODOLOGY

#### Study site

The study was conducted between September 2002 and September 2003 in the community of Langa, situated on the outskirts of Cape Town. Langa was established in the 1920s following the passage of the Urban Areas Act, which forced Africans to live in demarcated areas based on race. Today, Langa is a socio-economically heterogeneous community of approximately 60,000 residents. This is reflected in the diverse types of accommodation people live in, including an informal settlement area, rented accommodation (free-standing homes and flats), and home ownership, including formerly rented accommodation and suburban-type homes.

Interviews were also undertaken amongst health care providers and managers; provincial and national level policymakers, and representatives from non-governmental organizations (NGOs) and health professional bodies that influence policy. However, as previously stated, this study will focus on community participant's responses to possible future microbicide introduction.

South Africa was selected for this study because it has among the world's highest rates of HIV infection and AIDS related mortality (UNAIDS/WHO, 2004; Dorrington, Bradshaw & Budlender, 2002; Department of Health, 2002). South Africa is also the site for a

number of clinical trials and acceptability studies of microbicides (Mantell, et al., 2004). Given the country's relatively extensive clinical and regulatory experience with microbicides, and the urgency of the HIV/AIDS epidemic, it is likely that South Africa will be one of the first countries to introduce a microbicide once safety and effectiveness are established.

### **Study design**

Prior to the data collection process, consent was obtained from the City Health Department to conduct in-depth interviews with health care providers in Langa. Discussions were held with key community leaders to explain the project and to obtain their endorsement for conducting research in the community. A community liaison officer (CLO), a well-known resident of Langa, assisted in identifying and recruiting community participants. Institutional approval was obtained from the Research Ethics Committee, Faculty of Health Sciences at the University of Cape Town.

Qualitative research methods, focus group discussions and in-depth interviews, were used to collect data in the study site. Focus group discussions were held with both men and women residing in Langa, whereas, in-depth interviews were held with key informants. All were residents of Langa. A possible limitation of the study was that in-depth interviews were only held with key informants and not with community participants, as time constraints did not allow for this. Some individuals might have felt more comfortable conversing on a one-to-one basis, especially discussions of a more personal or private nature such as sexual practices.

The interview guides were semi-structured, open-ended and included probes for potential additional issues that could emerge as important concerns (see Appendix 1). Fieldworkers conducted the interviews in Xhosa, the local vernacular of community participants.

### **Sampling**

Focus group participants were identified using a combination of purposive and snowball sampling. The CLO was instrumental in identifying and recruiting community participants. Criteria for selecting community participants were: age 18 years and older, a resident of Langa, and willing and available to participate in focus group discussions. Focus group participants were approached by the CLO and briefly informed about the research project to determine their interest in participation. Those who fit the sampling criteria were invited to participate. Selection for the four “special” focus groups (sex workers and taverners) differed in that the CLO recruited 1 or 2 participants and they brought other participants to the sessions.

Twenty-two focus groups and 11 in-depth interviews were held with community participants. Community focus group participants all resided in Langa and were stratified by age, gender, and socioeconomic status, using housing type as a proxy (i.e., type of residence: rented, homeowners, or informal settlement). In addition, four focus groups were held with community members of special interest -sex workers and taverners. These two groups were seen as possible high-risk groups. Taverns or *shebeens* were located in Langa and were places where men met to socialize and drink alcohol. In Langa, women also visited the taverns including sex workers who often met clients there.

Focus groups were stratified by age and gender: younger women and men (18-25), older women (26-45), and older men (26-45)<sup>4</sup>. Stratifying focus groups by age and gender possibly allowed for more ease talking about sexual issues. The mean age of men and women participating in the focus groups was 31.2 and 30.5 years respectively.

Sixty-five percent of focus group participants owned or rented their homes and 95 percent were unemployed; there were no significant gender differences for both these categories. Gender differences were seen in schooling: more men (43.2 percent) than women (26.6 percent) had completed high school, but almost 16 percent of women as opposed to 5.4 percent of men had post-high school education.

Community key informants who participated in in-depth interviews included traditional healers, outreach workers, and individuals from key community organizations, including NGOs located in Langa.

### **Data collection**

Xhosa-speaking interviewers, three women and one man, conducted community focus group discussions and in-depth interviews. The interviewers participated in a three-day training workshop on qualitative research methods prior to undertaking the interviews. Most focus group discussions were held at the Langa library to ensure privacy and a quiet space for discussions. Focus group discussions consisted of seven to ten participants and lasted for approximately an hour. Informed consent was obtained from all participants

---

<sup>4</sup> A cut-off age of 45 was stipulated, however a number of participants over this age attended the focus group discussions.

prior to the start of any interview or discussion. For statistical purposes, socio-demographic characteristics were collected on all focus group participants (see Appendix 2). Along with a description of hypothetical microbicide products, an applicator similar to the one used in the Carraguard® clinical trials, was shown to community participants as one example of a potential microbicide product (see Appendix 3). Participants were able to visualise what the product might look like, which often resulted in lively discussions and commentary. The concept of a microbicide was explained to community participants as a potential HIV prevention method, to be applied as a gel or cream into the vagina or rectum. Participants were also informed that the first generation of microbicides would not be 100 % effective. Participant observation was not undertaken due to time constraints.

Each focus group participant received remuneration for expenses incurred for attending the sessions. With the consent of individual participants, all sessions were tape recorded and transcribed verbatim from Xhosa into English. The interviewers reviewed the transcriptions for accuracy and to ensure that meanings were not lost in translation.

### **Data analysis**

Data analysis was undertaken using a grounded theory approach, a process that allows researchers to “discover” categories, themes and patterns that emerge from the data (Strauss & Corbin, 1991). To facilitate the sorting and data management process, *Atlas.ti*, a qualitative software package was used for the analysis of the larger project. Selected identified themes and categories that emerged during the analysis phase of the larger

project were re-examined and further analysed for this study. These themes were related to gender and broader sexual relations and included notions of “wet sex”, suspicion and mistrust, contradictions emerging around a female initiated HIV prevention method, condom use, and gender based violence, including rape and sexual coercion. Time has allowed for further reflection on the research process and analysis and allowed me to explore in more depth certain issues that emerged which are more directly linked to gender and sexual relations.

Integral to an understanding of sexual relations are underlying gender power relations that exist between men and women. Furthermore, an understanding of gender related factors is crucial in exploring women’s access and ability to use a microbicide.

## CHAPTER 4

### RESULTS

The numerous challenges facing microbicide introduction are reflected in the diverse and often innovative views expressed by community participants. This section presents results on issues that relate to responses from community participants, including key informants. Results from the other two levels of inquiry: service delivery and policy, are provided in detail in the report “Paving the Path”: Challenges to Microbicide Introduction A Qualitative Study in South Africa, February 2004.

Discussions amongst both women and men around microbicide use revealed numerous ways in which a new preventive technology could impact on broader gender relations. Issues around male condom use, partner communication, meanings attributed to changes in vaginal moisture levels, covert use, potential for partner discord, and sexual violence were linked by respondents to the varying ways in which the microbicide could impact on their daily lives.

Prior to discussing the above issues, however, a brief discussion of overall support for microbicides will provide a background to the emergence of community responses. It became clear that the strong support that emerged for microbicides needed to be understood in terms of the severity of the AIDS epidemic and the impact it had on people’s daily lives, key informants were particularly vocal on this issue.

Overwhelmed by the daily devastating effects of the AIDS epidemic and the everyday proximity of death, community participants generally supported introducing even a partially effective product due to the severity of the situation in their community and the need to take action. Utterances such as “*we are dying like fleas*” poignantly reflect how death and dying had permeated their everyday lives. A traditional healer further depicted the sheer enormity of the problem as “*our nation is dying*”. Dying or “*getting finished*” became predominant signifiers in the discourse on desperation and urgency. Community participants repeatedly spoke about their desire for protection in these terms. Microbicides were often seen as a deliverance from impending death and “*interesting for those who did not want to die*”.

Some respondents referred to less conventional prevention and treatment options. Prayer became an important adjunct in the “fight” against death attributed to AIDS. In response to the church’s possible support for microbicides, one woman’s response was:

*Mine [church] would support my decision to use it because we often pray for these diseases to end, and for the dying. So, I'm inclined to look at this method as part of that effort because it's helpful. It would reduce the number of deaths.*

--Woman (18-25 years)

Despite references to the devastating impact of the AIDS epidemic on people’s lives, the gendered dimensions of the AIDS epidemic was also recognised by many community

participants. A traditional healer, identified women as most likely to die from AIDS: *"[Women] are the main victims...as much as it kills the men as well, I think the women are ones who die most"*. While women and youth (including girls and young women) were most likely to be impacted by HIV and AIDS, they were also seen as most likely to benefit from microbicide use.

### **Sexual relations: Implications for sexual and intravaginal practices**

Community focus group participants were asked directly about how the microbicide might impact on sexual relations. Discussions were often frank and open and participants frequently spoke in the first person perhaps an indication of ease speaking about sexual matters. This was facilitated by focus groups being separated by gender.

#### *"Wet sex"- meanings attached to wetness*

Wetness, pertaining to the added moisture the microbicide as a gel could cause during sexual intercourse, emerged spontaneously as an all-pervasive concern amongst both women and men in every focus group discussion.

Wetness was discussed, for the most part, with three levels of meaning: a woman's vaginal wetness implying infidelity, the preference of men for a woman's vagina to be "not wet" for increased sexual pleasure, and the association of "wetness" with sexually transmitted infections. However, wetness associated with possible partner infidelity was an overriding concern.

### *Infidelity*

Being wet, described as “ubumanzi” in Xhosa, prior to sexual intercourse was equated with infidelity and “*sleeping around*”. The mistrust and conflict that could ensue was of concern to both women and men.

Women in focus groups indicated that their male partners might interpret the presence of added wetness due to the microbicide as a sign of infidelity or promiscuity as this interchange between two female focus group participants suggested:

*FGP<sup>5</sup> 1: I think some men won't be interested because they don't like wetness during sex, so some won't be interested due to the fact that it's a gel, and a gel is a liquid, so we will have the same problem because some won't like it.*

*FGP 2: If one goes to a man with the gel applied, he would have funny remarks that there's already someone you have slept with, because you are already wet.*

--Women (26-45 years)

Men spoke with candor about the possible reasons for added lubrication during sex and concurred with women's concerns that being wet could imply having had sex with someone else. However, they also spoke about natural wetness due to foreplay and sexual arousal and added wetness due to the microbicide being a gel or cream. This in turn presented a further problem, as it would be difficult to distinguish whether a woman was wet due to sexual arousal, the microbicide, or wet due to having had sex previously with another man.

---

<sup>5</sup> FGP is an abbreviation for focus group participant.

This possible conundrum was aptly depicted as:

*Men always have priorities when coming to sex. We know that women's vaginas are always moist. There are men who could get put off by the fact that it's wet and think they had sex with someone else. As much as we are aware that when a woman feels pleasure sexually she gets wet, so the gel could make a woman even wet.*

--Man (26-45 years)

Mistrust between partners emerged strongly in the arena of “wet sex” and the meanings attached to being wet prior to intercourse. A male taverner voiced his concern and highlighted issues of distrust:

*We should also consider this fact, I don't know whether this gel remains wet inside but if that is the case we should also consider that we might be tricked. A woman could claim that she is wet due to the microbicide, only to find there's nothing like that, she's been with another man.*

Notions that added wetness signified infidelity was not restricted to the microbicide's physical properties but also to possible implications of a woman wanting to use the microbicide and what it would mean for partner relations. Women felt that the mere act of using a microbicide could imply that one was “*sleeping around*” and could lead to suspicion and distrust. This was underscored by the possibilities of pre-empting suspicion by explaining to men “*why we are wet and why we are using it*”(woman, focus group

participant, 26-45 years). Related to this men were also eager to overcome a “*lack of trust*” displayed by women as to possible reasons for wanting to use an HIV prevention method:

*If only our women would listen to us just as we always listen to them or if we could get those [information] leaflets so that we can show them and they could also read for themselves, then they wouldn't shout at us due to a lack of trust.*

--Man (26-45 years)

*“Not wet sex”*

Community respondents were asked about “dry sex”, however, the focus group facilitators framed the questions around “dry sex” differently. The facilitator for the men’s focus groups merely asked how “dry sex” might affect sexual relations, whereas, the facilitators for the women’s focus groups referred to the insertion of various drying agents, such as “blue soap or snuff” to achieve a dry, “virgin-like” vagina.<sup>6</sup> Despite these disparities, both men and women did not appear to have any prior knowledge about the practice of “dry sex”. Dry sex became an ambiguous term interpreted in different ways and some women attributed their own meanings to the notion of “dry sex”. Nevertheless, community key informants and women in focus groups did speak about men’s preferences for the vagina to be dry or “not wet” during sexual intercourse, implying that wetness associated with microbicides could be perceived as negatively affecting sexual pleasure.

---

<sup>6</sup> This was the facilitator’s own interpretation of “dry sex” and was not part of the interview guide.

A number of women complained that men were not always sensitive to their sexual needs and preferred them to be “*dry and tight like a virgin*”, whereas a sex worker viewed “dry sex” as “*having intercourse for a long time with no partner ejaculating*”. A desire for a dry, tight and a virgin-like vagina was to be juxtaposed against being excessively wet symbolized by male focus group participants as “*entering a swamp*”.

Men’s sexual preferences were paramount in women’s discussions about sexual norms and practices. A woman suggested that microbicide developers needed to come out with a method that was tailored to men’s sexual preferences and suggested a method that was “*similar to a face cream and that evaporated quickly*” so as to allow for “dry sex”. The amount of microbicide to be used was of significance within the context of “wet sex”.

Younger women spoke about using small amounts of the microbicide to avoid additional wetness and the associated problems with being too wet. They spoke about inserting just enough “*to form a wall,*” but not too much to cause one to be “*too wet and slippery.*”

A young woman poignantly pointed out that ultimately it was not about “*dry sex or wet sex, but about safe sex*”.

#### *Wetness and STIs*

Being wet had other connotations and could imply being “*dirty*” or having an STI.

However, being wet was equated far more with infidelity and promiscuity.

A group of women from the informal settlement captured the multiple meanings of wetness:

*FGP1: In other situations, men may accuse you when you have used the cream saying that you are sleeping around because you are wet.*

*FGP2: Men are not interested at all in many things whether you are married or not, even the needle [contraceptive injection] which is used for pregnancy protection they are not in favor at all and they are saying it makes you wet.*

*FGP3: I don't think they can be interested in using this because they would keep on saying you are using this because you are hiding something - there is a sickness, which you have.*

--Women (26-45 years)

Both men and women struggled with the possible negative associations of wetness and the possibility that a partner had slept with someone else. This was also counterbalanced against being preferable to the condom. Many men weighed up the possibilities of being unsure of their partner's prior sexual liaisons against using a product that allowed for "skin on skin" and more intimate contact, albeit a wet one.

### ***Male condom use***

Focus group participants were not asked directly about condom use or safe sex practices, discussions emerged spontaneously amongst all participants. The focus group forum provided an open space to discuss difficulties associated with condoms, particularly in

the light of being offered a perceived alternative, the microbicide. A predominant theme to emerge in discussions around the microbicide and its impact on relationship dynamics centered around men's, and, to a lesser extent, women's reluctance to use male condoms. Discussions around condoms emerged at different levels, relating to the difficulties associated with condom use, interference with sexual pleasure, difficulties negotiating condoms, opportunities for sexual autonomy, stigma, and, the different contexts in which condoms are used.

There was an overwhelming agreement by both men and women in terms of how the condom impacted negatively on sexual pleasure and performance. While men were more outspoken in their dislike of condoms, some women too felt it interfered with spontaneity and sexual performance as reflected in the following comment:

*What will give interest in this cream is the fact that we won't have to use a condom anymore, which is what men want, so when applying the cream underneath, men will be happy. There will be no problems like there were previously with a condom. It will now be the flesh on flesh that they insist.*

--Woman (26-45 years)

Similarly, another woman felt that:

*...this cream is a much better method, because men say that they don't want to eat a sweet covered in a wrap paper, so I therefore think that with this cream they will be able to eat the sweet without the wrap, as they prefer it.*

--Woman (26-45 years)

Both men and women grappled with the implications of using a microbicide. On the one hand, they stated that they did not like condoms and would be keen to try an alternative product, yet some men were reluctant to stop using condoms, as they were concerned about the microbicide's effectiveness in preventing HIV transmission. Respondents were frank and open about their dislike for condoms.

### *Sexual pleasure*

Most men and women spoke about the difficulties associated with male condoms such as they "*burst and remained inside the vagina*", interfered with sexual pleasure and performance, and spontaneity, and did not allow for "*skin-to-skin*" or "*flesh-to-flesh*" contact.

A key informant summed up the situation:

*People feel that one can't enjoy sex with a condom. When the condom was introduced, there were jokes doing the rounds like, one can't eat a sweet with a wrapper on. So, people ignore the fact that HIV infections are mostly spread through unprotected sexual intercourse and choose not to use a condom for personal reasons, which for the most part are that sex is not enjoyable when one is using a condom.*

Women frequently mentioned men's reluctance and/or refusal to use condoms. The microbicide would thus not only provide them with a female initiated HIV prevention

alternative but one that was also “*attractive*” to men as they would not be the ones to “*put it on*”.

Similarly, male focus group respondents felt that with the introduction of the microbicide they would no longer need to use a condom and would hence “*welcome this method*”.

*I don't see any reason why men would ignore this method, because this using a condom should be done away with. We now know there's this one, besides it's the same as doing nothing at all when using a condom. I think a lot of people would welcome this method. It's not the same as the condom in the sense that one doesn't have to carry it all the time.*

-- Man (26-45 years)

Women in focus groups expressed similar sentiments with regards to no longer having to use condoms, and that “*men would go for any method that's safe and doesn't require them to wear a condom*”. Issues around condom substitution (consistent condom users switching to microbicides) were not clear-cut and male respondents explored the possible implications of not using a condom versus using a product that was not “*100 % effective*” and where “*security was not guaranteed*”.

Many women acknowledged the difficulties they faced in negotiating condoms and men's resistance to using condoms, asserting that “*men do not want to use condoms*”, and

that when wanting to use condoms it often results in “*conflict and mistrust*” or “*not having sex at all*”.

Men in focus groups were not uniform in their attitudes towards condoms, recognising that “*people are not all the same*” and voiced concerns about the microbicide’s effectiveness. An older group of men appeared to be more supportive of condoms and wanted to ensure their partner’s safety and had become accustomed to the idea of using a condom, reflected in the following comment:

*I think we somehow got used to the idea of a condom that it doesn't put one off anymore, whether one likes it or not, no one has ever regretted not using a condom afterwards instead they get happy because it means you have taken a step further and not just doing it for pleasure.*

--Man (26-45 years)

### *Stigma*

A theme to emerge during discussions around condom use was a sense of mistrust and unease in sexual relations. Women often spoke about how men placed their health at risk by “*deliberately breaking condoms and puncturing them with a pin*” particularly in situations where men were asked to use condoms.

Stigma and possible sexual coercion associated with requests to practice safe sex and hence use condoms was highlighted by a group of women.

*Our boyfriends are stubborn and they sometimes force themselves on us and take offence at the suggestion of safe sex. They take that as an implication that they might have AIDS forgetting that one is trying to protect them as well. So, this would be very helpful.*

--Woman (26-45 years)

An older male respondent concurred with this sentiment, asserting that:

*One becomes a laughing stock when using this condom. One doesn't feel happy around others. They make a joke out of you saying you are lying you have AIDS.*

#### *Differing contexts of condom use*

While the different contexts in which condoms were used were not fully explored, nor were they asked, some insight can be gained from discussions about the particular circumstances and types of relationships in which condoms were used. Condom use was problematic amongst married women and some women suggested that men have “*other sexual partners who they use condoms with, and not with their wives*”. Some men agreed, stating that they might use condoms with “*girlfriends and younger partners and not with their wives*”.

### *Impact on fertility*

Women and men explored the relationship between condom use, the microbicide and fertility. Focus group participants were not asked directly whether the microbicide should have contraceptive properties. Despite this, both women and men spontaneously raised fears about a possible adverse impact on fertility and suggested that the microbicide should not “*make one unable to bear children*”. Some women suggested that men would not support the microbicide if it prevented pregnancy, particularly married women, where the ability to produce children was important to the stability of the relationship. Both men and women attributed added properties to the microbicide, the inverse of dual protection, and linked to a further desire to replace the condom with the microbicide.

*I think they [men] would like it because they don't like the condom... men would see it as an opportunity to make children. So this would prevent HIV and also make it possible for them to make children unlike when using the condom.*

--Woman focus group participant (26-45 years)

Some male focus group participants suggested a complex process whereby the microbicide should “*sieve the sperm from the germ thus cleaning the sperm before it enters the womb*” and hence not interfering with conception. While the predominant view was that microbicides should not have contraceptive properties, some participants indicated they would like the option of a microbicide also acting as a contraceptive.

### *Suspicion and mistrust*

Suspicion and mistrust were articulated by both male and female respondents on many levels and did not only extend to sexual and gender relations but to issues of a broader nature within the current South African socio-political climate. These ranged from mistrust between partners and the possibilities of covert microbicide use, to would the microbicide be safe and effective prior to introduction. Uncertainty also extended to people's everyday safety and mortality.

### *Proof of safety and effectiveness*

Men and women in focus groups expressed a desire for information about whether microbicides were "*successful and safe*". In a group of taverners, several men were afraid that people would begin using microbicides and only later come to learn that they were not "*100% effective*" in preventing HIV/AIDS. Several focus group participants were familiar with ongoing clinical trials in Cape Town and requested additional information about their progress and results. In addition to the written dissemination of study results, one participant suggested it would be useful to bring a person who had personally used the microbicide in order to testify to its effectiveness, stating: "*I'd like to see physical evidence, like be shown people who have taken part in the trials*".

Another respondent felt it would be beneficial if people from within their community were taken to a laboratory and informed how microbicides work.

He further explained, "*It's important that a black person explains to another black person as opposed to a white person*".<sup>7</sup>

---

<sup>7</sup> Within South Africa, experiences of racial classification established under apartheid would inform the manner in which researchers are perceived by the community into which they enter.

A lengthy interchange amongst a group of male taverners suggested high levels of distrust with organizations from the United States testing their products on local communities first, before introducing them in the America.

*FGP: I don't want to politicize this but they are using us a dumping place.*

*Everything the Americans want to try, they try on us, firstly has it worked over there?*

*INT: It's still being tested.*

*FGP: They start on us, they haven't started with it over there.*

*INT: Like I've already said, it's being developed abroad.*

*FGP: So, they haven't checked how effective it is, but they want to start on us? ...*

*So, this must first be tested over there before they bring it here.*

Questions arose as to who should be involved in these safety trials. Some suggested people whose life had lesser value due to crimes committed, namely, *"life term prisoners and serial murderers, or "people who already had AIDS and were going to die in any case"*.

#### *Product characteristics*

Discussions around the microbicide's physical properties suggested a certain level of mistrust between both men and women. However, in some situations both men and women expressed support for open communication about using microbicides and that communicating with partners about microbicide use was both important and potentially

possible. Added wetness was an overwhelming concern as previously discussed, however, other physical properties discussed by community members were related to sensorial experiences such as an unusual smell, texture, colour and visibility.

For instance, a group of male taverners wanted tangible proof that their sexual partners were in fact using the microbicide. Ensuring that the product was visible was linked to the product being colourless and hence difficult to see. The taverns were poorly lit further compromising their ability to ensure that the product was being used. According to them, women that they met at the taverns were “easy” and “even if they [men] wanted to use the cream maybe they [women] would be against using it”. Moreover, mistrust and cultural norms further hampered them in their quest to ensure that their partners were in fact using the microbicide. A taverner entertained the possibility that a woman may claim to have inserted the microbicide whereas in fact she had not. So:

*...To avoid being tricked... One would therefore need to inspect her vagina to see if it's been put on. And maybe it won't be possible to see anything because it's already been absorbed. And as black men it's not our custom to go, as far as to inspect women's vaginas, we are scared of bad luck.*

### ***Partner communication***

Many women felt that communicating with their partners about microbicide use was both important and possible. They thought that some men would be interested in using microbicides if they consulted with them beforehand and explained to them their reasons

for using it. This perception was confirmed as this interchange between two men suggests:

*FGP: 1 Women can convince men on anything, they have good marketing skills.*

*FGP: 2 Men are also easy to convince, so if this will be admitted by women and moreover get used by them, we males will vote for it, because if a woman says I'm using such and such a method and you disagree you will end up giving in.*

--Men (26-45 years)

Similarly, women felt it was important that men were part of the process and that they should be able to provide input into what was essentially a process involving both partners. As one woman stated:

*They should be called here because this involves us both. They should hear what this is about so that they don't turn around and say we decide things on our own. Like you said this is for the protection of both partners, so, they should hear it. They should come and hear what we have to say and also give their opinion.*

--Woman (18-25 years)

### ***Covert use***

However, there was also recognition that partner involvement would not always be possible or preferable. In some situations, covert use would be a necessary alternative particularly where there was a lack of trust between partners and/or where women lacked the power to negotiate condom use and hence microbicide use.

Women discussed different ways in which covert use could be achieved. One woman suggested they tell their partners the microbicide is for “*cleaning oneself*”, as men were aware of vaginal products used for personal hygiene. However, another woman said that it would be “*nice*” if they could apply the microbicide in front of partners, and preferable if “*partners could trust each other as opposed to applying it on the side*”. Yet, others said it would be hard to hide particularly if it was a gel that caused wetness and would thus preclude covert use. A group of sexworkers suggested a different route of administration by surreptitiously placing the microbicide in their partner’s tea or food.

Ironically, a group of men spoke about how the microbicide would enable women to have some “*power and control*” over their sexual practices. A group of younger women echoed similar sentiments and spoke about opportunities to take control of their lives and ensure their own safety. As one woman said: “*When one wants the partner to wear a condom they refuse and accuse one of sleeping around, but with this, one is in control. One can simply put it on and be safe.*”

### **Gender-based violence: rape and sexual coercion**

Issues around rape and sexual coercion arose spontaneously as key concerns amongst both women and men. A predominant theme to emerge was the desire to have a microbicide that would be long acting, and that could be inserted before leaving home as a routine practice in the event of being raped. In addition to their own fears, both men and women raised the possibility of young children being raped. None of these possibilities

was asked about directly or probed for, however participants raised them in most focus group discussions and suggests that sexual violence had become a part of their every day life experiences, as had death and dying due to the AIDS epidemic.

Women anticipated that microbicides would afford protection in case of rape for an unspecified, yet lengthy, period. One woman said she would *“prefer that it’s used all the time, as it could so happen that one gets raped”*. Women could leave their homes prepared for any eventuality because they could apply the substance beforehand. Some men also supported women’s preference for a method that was long-lasting and could be used routinely due to the high risk of women being raped: *“I wish it gets applied all the time because one wouldn’t know if they [women] could get raped”*.

Rape and sexual coercion appeared to be affecting women across the lifecycle. The possibility of young children being raped was frequently raised in focus group discussions. As an older woman said: *“It’s important for 5 year olds as well, because you could leave a child only to be some man’s rape victim”*. Respondents were sensitive to children’s vulnerability and suggested no age restrictions for microbicide use.

#### *Intentional infection: a form of gender-based violence*

Another instance in which the microbicide could be used pre-emptively was in situations of deliberate infection. Women felt that they could use a microbicide to protect themselves against anyone who might be trying to infect them through rape or deceit about their HIV-status. A young woman viewed the microbicide as being *“very helpful*

*people commit rape in order to spread the disease*". These concerns were also raised by a male focus group participant who saw microbicides as potentially providing a solution, especially one that was fully protective against infection:

*If it could be 100 percent effective, women will use it a lot, because there are AIDS-infected men who rape women, so a woman would walk in the streets knowing very well that she is protected even if an AIDS-infected person would rape her.*

-- Man (26-45 years)

For the most part people did not speak about sexual violence and rape within relationships or within the domestic sphere, rather rape was attributed to occurring in places external to the home, such as when "*going out, walking in the streets at night and at parties*". A group of women homeowners seemed to think, "*a lot of rape and adultery occurs in informal settlements*" further placing rape "*out there*".

## CHAPTER 5

### DISCUSSION

Community respondents voiced a broad range of perceptions and understandings with regards to microbicide use, however, certain issues were of central concern. Reasons for supporting microbicides tended to focus on the desperate need for more prevention options in light of the HIV/AIDS epidemic, the recognition that many individuals do not or are unable to use condoms, and the limited power of women to negotiate a male-dependent HIV prevention method. In addition, a wide range of individual concerns and questions about microbicides emerged from the data.

Women's relative lack of power was evidenced in numerous ways, such as, wanting protection against infection in the event of being raped, the negative implications of added vaginal lubrication, and problems associated with negotiating condom use. However, despite a general sense of unease and mistrust with regards to sexual and gender relations, and the perceived impact that a new female-initiated prevention technology would have on these relations, both women and men did feel that opportunities existed for open communication and partner involvement in risk reduction practices. Susser & Stein (2000), have argued that contrary to the prevalent view of African women as helpless victims, many women saw themselves as active participants in the search for a way to protect themselves in situations that placed them at risk. The microbicide was seen as a marker of autonomy and affecting their own sexual agency.

A woman's comfort with using microbicides and her perceptions of the feasibility and potential ramifications of microbicide use are likely to be informed by her experience with other intravaginal products as well as sexual practices, cultural norms and gender relations (Braunstein & van de Wijgert, 2003). As previously highlighted, an understanding of local sexual practices, underlying gender relations and possible sites of resistance are crucial to understanding how new technologies will be received. Inequitable gender relations could create barriers and preclude attempts to introduce a new HIV prevention technology such as the microbicide. The meanings attached to "wetness" support this view.

Mistrust between partners emerged strongly in the arena of "wet sex" and the varied meanings attached to being wet prior to sexual intercourse. It became clear that repeated references to "wet sex" and what this would mean for partner relations was suggestive of underlying gender power dynamics. A natural correlation was made between the microbicide's properties as a gel or cream and the problems associated with "wet" sex which in turn could impact on sexual pleasure and partner relations. Despite the varied meanings attached to wetness, wetness associated with possible partner infidelity was an overriding concern. However, associations of added wetness or vaginal lubrication during sex with promiscuity and infidelity are not peculiar to this community. Similar issues were to emerge in study settings as diverse as amongst male factory workers in Zimbabwe (Ray, Gumbo & Mbizvo, 1996) and amongst drug-involved women in the USA and Puerto Rico (Mason et al., 2003).

Embedded in notions of infidelity were inequitable gender relations - men appeared to claim a sense of entitlement and control over how sexual relations needed to be played out. However, contradictions did emerge and in other situations both men and women spoke about the need for frank and open communication with regards to microbicide use. This would suggest that gender identities are not fixed, but are often fluid, contradictory and change over time (Annandale & Clarke, 1996; Fraser, 1992) and further underscores the need to pay attention to the manner in which gender relations are constructed and contested.

Notions of infidelity were also to emerge with regards to condom use. Women's requests for partners to use condoms was often interpreted as yet another signifier of infidelity and raises the issue that new prevention technologies/strategies aimed at empowering women or giving them opportunities for sexual autonomy might meet resistance from male partners, and highlights the importance of including men in risk reduction norms and practices. The International Conference on Population and Development held in Cairo in 1994 provided an important shift in thinking about men's involvement in women's sexual and reproductive health initiatives (UN, 1995). Since Cairo, there have been many initiatives to encourage men to change attitudes and behaviours that endanger women's health. The Men As Partners Project (a collaboration between Planned Parenthood Association of South Africa and EngenderHealth) has demonstrated significant success in shifting men's attitudes about gender equity and violence against women (Kruger, 2000). While issues around men's involvement was not the central focus of the larger research project, insight gleaned from a closer examination of gender relations would suggest

possibilities for men's involvement in women's sexual and reproductive health initiatives.

Although elsewhere in Southern Africa, preferences for "dry sex" to increase sexual pleasure has been reported (Brown & Brown, 1999; Civic & Wilson, 1996; Sandala et al., 1995) most focus group participants were not familiar with the practice of "dry sex". Although community respondents were not familiar with pre-conceived definitions of "dry sex", a penchant for a "dry, tight and virgin-like vagina" to enhance men's sexual pleasure (Civic & Wilson, 1996; Ray, Gumbo & Mbizvo, 1996) resonated in this study as well. Further probing might have elicited other sexual preferences, however, our findings would suggest that wetness was seen as a metaphor for promiscuity, distrust and more literally being wet due to a previous partner's semen, all issues that could further confound the sexual encounter. The varied interpretations of "wetness" and unfamiliarity with the practice of "dry sex" underscores the need to pay particular attention to local social context, rather than relying on universalising assumptions about sexual norms or preferences (Kaler, 2001).

The possibility of condom substitution has often been cited as a potential barrier to the widespread endorsement of microbicides as a potential method of HIV prevention (Foss, Vickerman, Heise & Watts, 2003; Heise, 1999). Discussions around microbicide use and possible condom substitution were complex and respondents interrogated all possibilities and options. There was a range of opinions around the potential impact of microbicides on condom use, more specifically, whether people would abandon condoms

in favour of microbicides. Although the reasons for possibly switching from condoms to microbicides were often couched in terms of sexual preferences they also depicted underlying gender power relations. However, commentary around condom use suggested that in certain situations, such as open communication between partners, women were able to negotiate condom use and hence envisaged they would be able to negotiate using a microbicide.

A central contradiction emerged in community respondents' discussions around condoms and how they impacted negatively on sexual pleasure and performance, and the overwhelming support for the microbicide, underscored by the desperate need to halt the devastating effects of the AIDS epidemic. A tension existed between sexual desire and pleasure, and placing oneself at risk by not using condoms despite acknowledgement of mounting HIV infections and AIDS-related deaths. This in turn could influence how microbicides will be received and might be seen as an important alternative HIV prevention technology for both women and men. Given the relatively long timeframe for microbicide development and introduction in South Africa, this issue will need to be re-examined.

While we do not have figures of actual condom use in this research site, the fact that almost all participants at some point spoke about difficulties associated with condom use would suggest that condom use was not normative in this community. This is somewhat dissimilar to a recent study investigating the behavioural responses of South African youth to the AIDS epidemic, condom use at last sexual intercourse was high at 52.8% for

males and 47.6 % for females especially among Africans living in urban informal settings (Simbayi, Chauveau & Shisana, 2004). This study was undertaken amongst a younger age group (15-24) whereas the median age range in our study was older at 31.2 years for men and 30.5 years for women and might explain some of the differences.

While there were no suggestions that respondents associated stigma with microbicide use or with women who might use them, discussions suggested that stigma was associated with condom use. However, issues of stigma are complex and once microbicides become a reality and available issues around stigma may emerge.

A perhaps not unpredictable, yet not anticipated, issue to emerge amongst both women and men were concerns about the microbicide's possible impact on fertility. This is perhaps not surprising in a country where 61% of sexually active women aged between 15 to 49 years use some form of contraception (Department of Health, 2002). On one level, one can assume a high prevalence of contraceptive use in this community and thus for the microbicide to have additional contraceptive properties was not an important issue. Yet, this would not explain why both women and **men** were equally concerned about the microbicide's impact on fertility. Perhaps people were exploring all the possible options that the microbicide could provide in their day-to-day lives. The importance of motherhood and the strong desire to have children in many communities might also be an additional reason. Concerns around possible adverse effects on fertility reaffirms the importance of consulting with local communities and key stakeholders prior

to the introduction of new reproductive health technologies (Hardon, Mutua, Kabir & Engelkes, 1997; Simmons et al., 1997).

A sense of suspicion and mistrust were articulated by both male and female respondents on many levels and did not only extend to sexual and gender relations but to issues of a broader nature within the current South African socio-political climate. Desire for proof of the microbicide's safety and effectiveness prior to introduction would suggest high levels of distrust in this community towards foreign drug companies and organizations conducting clinical trials in South Africa. The recent concerns elsewhere in Africa about ethical conduct and the need for wider stakeholder participation in HIV prevention trials has resulted in clinical trials being halted due to active engagement by various stakeholders around the need for community participation and consultation not only in the preparatory stages but throughout the entire process (African Microbicides Advocacy Group eForum, 2005).

At times an overwhelming sense of mistrust between men and women would suggest that gender relations, particularly within the sexual realm, were fraught with difficulties and would have to be acknowledged prior to introducing any new woman- initiated technology.

Notwithstanding the above, there were suggestions that both men and women would welcome open, partner communication about using microbicides. The paradoxes and

discontinuities to emerge around possible microbicide use as they related to broader gender and sexual relations were a reflection of the complexities in people's lives. More practical concerns linked to the microbicide's physical properties and confirming that women were in fact using the product can be linked to underlying gender power dynamics and possible covert use. Experience with other health technologies such as the contraceptive injection has resulted in similar concerns in relation to visibility (Harries, 1998).

Findings from this study would suggest that new technologies creating a degree of sexual autonomy could be perceived by men as gendered and not neutral medical technology and thus its medical efficacy may take second place to its impact on gender relations. Reception may not be solely determined by public health norms and concerns, but may be filtered through existing gender norms. Threats to gender power relations may be perceived by men as a greater or equal risk factor than HIV transmission. This perceptual bias will impact on new HIV prevention technologies introduced in South Africa, and has important implications for implementation strategies, and raises the question of whether negotiating microbicides will be as difficult as negotiating condoms.

The potential for microbicides to be used more discreetly than condoms is an important, anticipated product characteristic. Although women will most likely see it as a positive attribute, men may perceive it as negative. Men might dislike the possibility of being exposed to the microbicide without their knowledge or the idea that their partner can exercise such autonomy. Microbicides do not require the active participation or even

knowledge of the partner. How a woman decides to use a new product is a complex process - a balance of her perception of risk, understanding the product and how it works, anticipation of her partner's reaction to use and consideration of the relationship's balance of power. Use of microbicides, theoretically under a woman's control, may not be possible if she has no decision-making power in sexual activities (Woodsong, 2004, p. 94). Furthermore, translating the idea of covert use into actual practice could be problematic. However, women made some suggestions as to how this could be achieved.

Covert use could take different forms with some strategies more secret than others. Women in steady, long term relationships might find it difficult to use a microbicide with their partner - just as they would find it difficult to use a condom, whereas, in other more casual relationships it might be easier. Green et al., (2001) in a study on women's use of vaginal products in Uganda discovered that women found it difficult to maintain covert use over time and that maintaining covert use was more possible with casual relationships than with more long term relationships. We did not really explore in what circumstances or types of relationships microbicide use (covert or overt) would be possible, a limitation of the research. However, information gleaned from respondents would suggest complex decision-making in relationships with respect to condoms, which could be translated to possible microbicide use.

Perhaps one of the most disquieting aspects of gender relations was both women and men's discussions around gender-based violence, more specifically rape. The microbicide was seen as a pre-emptive HIV prevention "tool" in the event of being raped. Similarly,

in other settings, the female condom was also seen as providing protection against infection and pregnancy if raped (Kaler, 2001).

However, it would be difficult to assess levels of intimate partner violence or sexual abuse within relationships as participants might have found it extremely difficult to speak of intimate partner violence in a focus group setting. Nevertheless, frequent references to rape would suggest that rape is viewed as common - almost a part of everyday life. Given the high levels of violence against women reported in South Africa (Dunkle et al, 2004; Jewkes & Abrahams, 2002), this perception is not surprising. South Africa has the highest per capita rate of **reported** rape in the world (115.6 for every 100 000 of the population in 1998). For various reasons, rape is both a very under-reported and sometimes an inappropriately reported crime (Rape Crisis, South Africa, 2005).

Use of microbicides in situations of rape and sexual coercion assumes women's ability to apply a microbicide as part of a daily routine. This implies that microbicides developed and introduced would need a relatively long duration of action. While it is unknown whether microbicides could meet these expectations, people clearly desired a protective method against HIV that could be used on a routine basis. Recognition that unequal gender power relations underlying gender-based violence cannot be addressed solely by the introduction of new women-initiated technologies is critical. Rather, this would require comprehensive policies and interventions to promote equity in gender relations at all levels of South African society, which would include economic and political levels.

Participant's candor and apparent ease speaking about sexual relations and the possible impact that a new prevention technology could have on sexual and gender relations could possibly be a result of exposure through public discourse and the activities of civil society organizations in the area of HIV/AIDS.

Furthermore, it is important to bear in mind that throughout these discussions participants were talking about a hypothetical product, however, it provided a space for them to talk about day-to-day issues, which could influence microbicide use and provided important information on condom use and practices.

University of Cape Town

## CHAPTER 6

### CONCLUSION

Insights gained from a re-examination of community respondents' perceptions around possible microbicide introduction revealed differing ways in which gender and partner relations could influence the introduction of a female-initiated HIV prevention technology such as the microbicide. Furthermore, a sense of desperation and urgency, coupled by the devastating effects of the AIDS epidemic on people's lives, underscored the urgent need for such a product.

While some of the results, such as, the practice of "dry sex" and preference for non-contraceptive properties may be specific to local context, others, such as the strong desire to prove safety and effectiveness may not and should be heeded in microbicide introduction strategies.

A new and interesting perspective to emerge was the desire for male partner involvement in microbicide introduction strategies. At the same time, positive feelings towards opportunities for mutual agreement between partners were interwoven with feelings of fearfulness and doubt that negotiation would be possible. In this sense, women's relative lack of power in sexual relationships could be both a barrier and an incentive to microbicide use.

Women's vulnerable position particularly with regards to protecting themselves from HIV/AIDS and STIs were expressed in numerous ways, which were often related to men's reluctance to use condoms, multiple meanings attached to wetness and overall distrust. The microbicide was thus seen as a means to assert their own agency most notably in their protection against rape and sexual coercion.

While the opinions of community respondents with regards to microbicide use might be of a hypothetical nature they do however provide important insight into partner and sexual relations, discussions around gender based violence and problems associated with condom use. Successful and rapid introduction of microbicides, once they are approved and available, will clearly require further research and careful preparation.

A general sense of unease and mistrust extended beyond gender relations and were also located in the wider social environment and will need to be addressed in social marketing strategies should microbicides become available. In addition, the strong desire for data to prove the microbicide's safety and effectiveness can be linked to South Africa's historical past where under apartheid black South Africans were denied basic human rights and were frequently recipients of coercive health care policies and practices.

A central issue to emerge in this study is the need to address gender inequities, which emerged in discussions around the need for a female-initiated HIV prevention method, and around issues of rape, wetness and partner involvement. While community respondents tended to view the microbicide as a possible panacea for dealing with most

of these issues, inequitable gender relations and other social and economic problems will need to be addressed in order to halt the spread of the AIDS epidemic in South Africa.

University of Cape Town

## REFERENCES

- Abdool Karim, Q., & Abdool Karim, S.S. (1999). South Africa: Host to a new and emerging HIV epidemic. *Sexually Transmitted Infections*, 75(3), 139-140.
- African Microbicides Advocacy Group eForum June 6, 2005, <http://www.global-campaign.org/amag.htm>. [amag@dgroups.org](mailto:amag@dgroups.org).
- Alliance for Microbicide Development. (2003). *Microbicide research and development Products database*. Silver Springs, MD: Alliance for Microbicide Development.
- Annandale, E., & Clark, J. (1996). What is gender? Feminist theory and the sociology of human reproduction. *Sociology of Health & Illness*, 18, 17-44.
- Beksinska, M. E., Rees, H. V., Kleinschmidt, I., & McIntyre, J. (1999). The practice and prevalence of dry sex among men and women in South Africa: A risk factor for sexually transmitted infections? *Sexually Transmitted Infections*, 75(3), 178-180.
- Bradshaw, D., Laubscher, R., Dorrington, R., Bourne, D., & Timaeus, I.M. (2004). Unabated rise in number of adult deaths in South Africa. *South African Medical Journal*, 94, 278-279.
- Braidotti, R. (1991). *Patterns of Dissonance*. Cambridge: Polity Press.

Braunstein, S., & van de Wijgert, J. (2003). Cultural norms and behavior regarding vaginal lubrication during sex: Implications for the acceptability of vaginal microbicides for the prevention of HIV/STIs. *Critical Issues in Reproductive Health*. New York, NY: Population Council.

Brown, J., Ayowa, O., & Brown, R. (1993). Dry and tight: Sexual practices and potential AIDS risk in Zaire. *Social Science and Medicine*, 37(8), 989-994.

Coggins, C., Blanchard, K., & Friedland, B. (2000). Men's attitudes towards a potential vaginal microbicide in Zimbabwe, Mexico and the USA. *Reproductive Health Matters*, 8(15), 132-141.

Cooper, D., Morroni, C., Ormer, P., Moodley, J., Harries, J., Cullingworth, L., & Hoffman, M. (2004). Ten years of democracy in South Africa: Documenting transformation in reproductive health policy and status. *Reproductive Health Matters*, 12(24), 70-85.

Civic, D., & Wilson, D. (1996). Dry sex in Zimbabwe and implications for condom use. *Social Science and Medicine*, 42(1), 91-98.

Dallabetta, G. A., Miotti, P. G., Chipangwi, J. D., Liomba, G., Canner, J. K., & Saah, A. J. (1995). Traditional vaginal agents: Use and association with HIV infection in Malawian women. *AIDS*, 9, 293-297.

De Lauretis, T. (1986). *Feminist Studies: Critical Studies*. Bloomington: Indiana University Press.

Department of Health of the Republic of South Africa. (2004). *National HIV and syphilis antenatal sero-prevalence survey in South Africa*, Department of Health, Republic of South Africa. Retrieved August 1, 2005, from <http://www.doh.gov.za/aids>.

Department of Health of the Republic of South Africa. (2002). South African Demographic and Health Survey 1998: Full Report. Pretoria: South African Medical Research Council, South African Department of Health, and Macro International.

Dorrington, R., Bradshaw, D., & Budlender, D. (2002). HIV/AIDS profile for the provinces of South Africa: Indicators for 2002. Cape Town: Centre for Actuarial Research, University of Cape Town, Actuarial Society of South Africa, Burden of Disease Research Unit, South African Medical Research Council.

Dunkle, K., Jewkes, R., Brown, H., Gray, G., McIntyre, J., & Harlow, S. (2004). Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *Lancet*, 363(9419), 1415-1421.

Elias, C., & Coggins, C. (2001). Acceptability research on female -controlled barrier methods to prevent heterosexual transmission of HIV: Where have we been? Where are we going? *Journal of Women's Health & Gender-Based Medicine*, 10(2), 163-173.

Elias, C., & Heise, L. (1993). The development of microbicides: A new method of HIV prevention for women. *Population Council Working Paper*, No.6.

Foss, A. M., Vickerman, P. T., Heise, L., & Watts, C. H. (2003). Shifts in condom use following microbicide introduction: Should we be concerned? *AIDS*, 17(8), 1227-1237.

Fraser, N. (1992). The uses and abuses of French discourse: Theories for feminist politics, *Theory, Culture & Society*, 9(1), 51-71.

Ginsburg, F., & Rapp, R. (1995). *Conceiving the new world order: The global politics of reproduction*. Berkeley: University of California Press.

Green, G., Pool, R., Harrison, S., Hart, G., Wilkinson, J., Nyanzi, S., & Whitworth, J. (2001). Female control of sexuality: Illusion or reality? Use of vaginal products in south west Uganda. *Social Science and Medicine*, 52, 585-598.

- Groenewald, P., Nannan, N., Bourne, D., Laubscher, R., & Bradshaw, D. (2005). Identifying deaths from AIDS in South Africa. *AIDS*, 19, 193-201.
- Hardee, K., Balogh, R. T., & Villinski, M. T. (1997). Three countries' experience with Norplant introduction. *Health Policy and Planning*, 12(3), 199-213.
- Hardon, A., Mutua, A., Kabir, S., & Engelkes, E. (1997). *Monitoring family planning and reproductive rights: A manual for empowerment*. London: Zed Books.
- Harries, J. (1998). Body literacy and family planning in a Cape Town day hospital. *Medische Anthropologie Jaargang* 10(1), 33-40.
- Heise, L. (1999). *Topical microbicides*. Takoma Park, MD: Center for Health & Gender Equity.
- Hoffman, S., Mantell, J., Exner, T., & Stein, Z. (2004). The future of the female condom. *International Family Planning Perspectives*, 30(3), 139-145.
- Jewkes, R., & Abrahams, N. (2002). The epidemiology of rape and sexual coercion in South Africa: An overview. *Social Science & Medicine*, 55(7), 1231-1244.

Kaler, A. (2001). "It's some kind of female empowerment": The ambiguity of the female condom as a marker of female empowerment. *Social Science and Medicine*, 52(5), 783-796.

Karim, Q. A., Karim, S. S., Soldan, K., & Zondi, M (1995). Reducing the risk of HIV infection among South African sexworkers at truck stops in Kwa-Zulu Natal. *American Journal of Public Health*, 85, 1521-1525.

Kruger, V. (2000). *Evaluation report: Men as partners program.*, Project Evaluation and Research Service.

Mann, J. M., Nzilambi, N., Piot, P., Bosenge, N., Kalala, M., Francis, H., Colebunders, R. C., Azila, P. K., Curran, J. W., & Quinn, T. C. (1998). HIV infection and associated risk factors in female prostitutes in Kinshasa, Zaire. *AIDS*, 2(4), 249-254.

Mantell, J. E., Myer, L., Carballo-Diequez, A., Stein, Z., Ramjee, G., Morar, N. S., & Harrison, P. F. (2005). Microbicide acceptability research: Current approaches and future directions. *Social Science and Medicine*, 60(2), 319-330.

Martin, E. (1989). *The woman in the body*. Milton Keynes: Open University Press.

- Mason, T. H., Foster, S. E., Finlinson, H. A., Morrow, K. M., Rosen, R., Vining, S., Joanis, C. L., Hammett, T. M., & Seage, G. R. (2003). Perspectives related to the potential use of vaginal microbicides among drug-involved women: Focus groups in three cities in the United States and Puerto Rico. *AIDS Behavior*, 7(4), 339-351.
- Minh-ha, T. (1989). *Woman, native, other: Writing, post-coloniality and feminism*. Bloomington: Indiana University Press.
- Mohanty, C. (1991). Under western eyes: feminist scholarship and colonial discourses. In C. Mohanty, A. Russo, L. Torres (Eds), *Third world women and the politics of feminism* (pp.53-65). Indianapolis: Indiana University Press.
- Moore, H. (1994). *A passion for difference*, Cambridge: Polity Press.
- Morar, N., & Karim, S. (1998). Vaginal insertions and douching practices among sex workers at truck stops in Kwa-Zulu Natal. *South African Medical Journal*, 88,470.
- Myer, L., Denny, L., De Souza, M., Barone, M., Wright, T., & Kuhn, L. (2004). Intravaginal practices, HIV and other sexually transmitted diseases among South African women. *Sexually Transmitted Diseases*, 31(3),174-179.
- Orner, P., Harries, J., Cooper, D., Moodley, J., McGrory, E., Becker, J., Dabash, R. & Bracken, H. (2004). "Paving the path": Challenges to microbicide introduction a qualitative study in South Africa.

Rape Crisis, South Africa (2005). Retrieved June 27 2005, from

<http://www.rapecrisis.org.za.htm>.

Ray, S., Gumbo, N., & Mbizvo, M (1996). Local Voices: What some Harare men say about preparation for sex. *Reproductive Health Matters*, 7, 34-45.

Rosenberg, Z. (2005) International Partnership for Microbicides, CEO, press release, June, 2.

Runganga, A., Pitts, M., & McMaster, J. (1992). The use of herbal and other agents to enhance sexual experience. *Social Science and Medicine*, 35, 1037-1042.

Sandala, L., Lurie, P., Sunkutu, M., R., Chani, E. M., Hudes, E. S. & Hearst, N. (1995). "Dry sex" and HIV infection among women attending a sexually transmitted diseases clinic in Lusaka, Zambia. *AIDS*, 9, S61-8.

Simbayi, L. C., Chauveau, J., & Shisana, O. (2004). Behavioural responses of South African youth to the HIV/AIDS epidemic: A nationwide survey. *AIDS Care*, 16(5), 605-618.

Simmons, R., Hall, P., Diaz, J., Diaz, M., Fajans, P., & Satia, J. (1997). The strategic approach to contraceptive introduction. *Studies in Family Planning*, 28(2), 79-94.

Strauss, A., & Corbin, J. (1991). *Basics of qualitative research*. Newbury Park, CA: Sage Publications.

Susser, I. & Stein, Z. (2000). Culture, sexuality, and women's agency in the prevention of HIV/AIDS in Southern Africa. *American Journal of Public Health*, 90(7), 1042-8.

Tuladhar, J., Donaldson, P. J., & Noble, J. (1998). The introduction and use of Norplant implants in Indonesia. *Studies in Family Planning*, 29(3), 291-299.

UNAIDS. (2004). *AIDS Epidemic Update*, December 2004. UNAIDS/03.39E. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization.

UN. (1995). Program of Action of the International Conference on Population and Development (Cairo) New York, United Nations.

van de Wijgert, J., Khumalo-Sakutukwa, G., Coggins, C., Dube, S., Nyamapfeni, P., Mwale, M., & Padian, N. (1999). Men's attitudes toward vaginal microbicides and microbicide trials in Zimbabwe. *International Family Planning Perspectives*, 25(1), 15-20

Wood, K., & Jewkes, R. (1997). Violence, rape, and sexual coercion: Everyday love in a South African township. *Gender and Development*, 5(2), 41-46.

Woodsong, C. (2004). Covert use of topical microbicides: Implications for acceptability and use. *International Family Planning Perspectives*, 30(2), 94-98.

University of Cape Town

## APPENDIX 1

### Interview guide for community focus group discussions

#### INTRODUCTION

As you probably already know, there is an HIV problem in South African communities. The health services, the communities and others are searching for ways to prevent HIV. Now, apart from having no sex or only having sex with one partner and this partner only having sex with you, condoms are the best method to prevent HIV. Researchers are trying to find other methods to prevent STIs and HIV infection, such as microbicides. A microbicide is a gel or cream that a person would put in the vagina or rectum before having sex that may help prevent the spread of HIV and other STIs. They may:

- Kill or otherwise stop STI germs;
- Stop infection by creating a barrier (e.g., like building a dam wall) between the germs and the vagina or rectum; or
- Stop infection from spreading after a germ has entered the body.

*Microbicides are still being studied and not yet available. Some products have been developed and are currently being tested to see if they are safe and effective. If proven*

*safe and effective and approved for use, microbicides may be available in a few years time.*

*However, the first microbicides will probably not be 100% effective. Because of this, condoms would still be the best method to stop infection. However, we know that people are not always able or willing to use condoms. In this situation, microbicides could provide some protection against infection. Since microbicides would be used by women, they would provide an important alternative for preventing HIV infection.*

1. Do you think women would be interested in using such a method?
  - What would make the method attractive to them?
  - What would make the method unattractive?
  
2. Do you think men would be interested in using such a method?
  - What would make the method attractive to them?
  - What would make the method unattractive?
  - How might this method affect sexual relations?
    - What about certain sexual practices, such as 'dry sex'?
  - Do you think women would want their partners to be involved in using the method? Why? In what ways?
  - What do you think men's attitudes would be about using this method?
  - Would you have any concerns about using this method?

- Do you think cost would affect decisions to use the method? If yes, how? If no, why not?
  - How much would people be willing to pay for such a method?
  - How will men and women feel about a method that will not protect them fully from infection?
    - o What would make them use such a method?
    - o What would make them decide not to use it?
3. Who do you think would want to use this method?
- Why would they want to?
  - What would help them use the method?
  - What might be some barriers to using this method?
4. Who do you think would NOT want to use the method?
- Why would they not want to use it?
5. Do you think this method will affect sexual pleasure?
- If yes, in what ways?
6. Where do you think people in your community would like to get information about this method?
7. Where do you think the method should be made available?

- Should it be available at health centres? Why? Why not?
  - Should it be available at spazas? Why? Why not?
  - What other places do you think it should be available? Why?
8. If a woman was thinking about using this method, who would influence the decision to use it or not to use it?
- Would friends or peers influence the decision?
  - Would family influence the decision?
  - Would health providers influence the decision?
  - Would organisations, such as the PPASA or religious organisations influence the decision?
  - Are there other people or organisations that may influence the decision to use or not use the method? If yes, who are they?
9. Do you have any other thoughts or questions?

Thank you for your time.

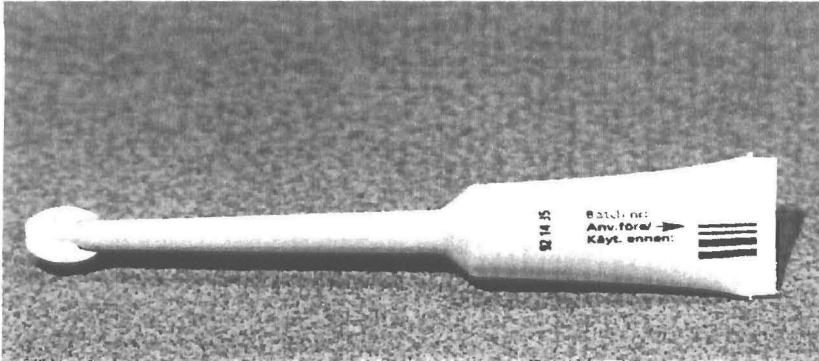
## APPENDIX 2

### Socio-demographic characteristics of community focus group participants

Characteristic	Men (n=75) n (%)	Women (n=129) n (%)
<i>Mean age (standard deviation)</i>	31.2 ( $\pm$ 7.8)	30.5 (8.6)
<i>Age range (years)</i>	18-45	18-58
<i>Age Group</i>		
<20 years	5 (6.7)	7 (5.4)
20-29 years	32 (42.7)	65 (50.4)
30-39 years	21 (28.0)	37 (28.7)
40-49 years	17 (22.6)	17 (13.2)
50-59 years	0 (0.0)	3 (2.3)
<i>Education*</i>		
Primary	17 (23.0)	19 (14.8)
Secondary	21 (28.4)	55 (43.0)
Matric	32 (43.2)	34 (26.6)
Post-matric	4 (5.4)	20 (15.6)
<i>Employment status*</i>		
Employed	4 (5.3)	7 (5.5)
Unemployed	71 (94.7)	121 (94.5)
<i>Type of housing*</i>		
Rent home	39 (52.0)	52 (41.3)
Own home	13 (17.3)	27 (21.4)
Informal settlement	23 (30.7)	47 (37.3)
<i>Marital status*</i>		
Married	17 (34.0)	19 (20.2)
Not married	33 (66.0)	75 (79.8)
<i>Partner status*</i>		
No partner	12 (42.9)	13 (23.2)
Lives with partner	15 (53.6)	21 (37.5)
Boyfriend/girlfriend,not cohabiting	1 (3.5)	22 (39.3)

*\*Indicates missing data.*

### APPENDIX 3



**Carraguard®**: one of several microbicide products currently in development, including some in Phase II and Phase III of clinical testing.

University of Cape Town